Griffin YMCA Early Learning Center
2025-2026 REGISTRATION FORM

General Information

Operation's Name: Griffin YMCA Early Learning Center **Director's Name:** Jade Maseda jademaseda@ymcagoldencrescent.org 361-551-2562

Child's Full Name_____ Date of Birth_____
Last *First* *MI*

Child's Home Address_____
Street Address *Apartment/Unit*

City_____ State_____ Zip_____

Child lives with: ☐ Both Parents ☐ Mom ☐ Dad ☐ Guardian

Name of Parent or Guardian Completing Form_____
Last *First* *MI*

Address (if different From child's)_____
Street Address *Apartment/Unit #*

City_____ State_____ Zip_____

List contact information where parents/guardian may be reached while child is in care:

Parent 1 Name_____ Date of Birth_____
Phone No._____ Email Address_____

Parent 2 Name:_____ Date of Birth:_____
Phone No._____ Email Address_____

Custody Documents on File? ☐ Yes ☐ No

Give the name, address, and phone number of the responsible individual to call in case of an emergency if parents/guardian cannot be reached:

Last_____ First_____ MI_____ Phone_____
Street Address_____ Apartment/Unit#_____
City_____ State_____ Zip_____

I authorize the child care operation to release my child to leave the child care operation **ONLY** with the following person(s). List name and telephone number for each. Children will only be released to a parent or guardian or to a person designated by the parent/guardian after the verification of I.D.

Name_____ Name_____ Name_____
Phone No._____ Phone No._____ Phone No._____

Consent Information

CHECK ALL THAT APPLY

1. TRANSPORTATION

I give consent for my child to be transported and supervised by the operation's employees:

☐ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school

2. FIELD TRIPS

☐ I give consent for my child to participate in field trips

☐ I do not give consent for my child to participate in field trips

Comments:_____

_____

3. WATER ACTIVITIES

I give consent for my child to participate in the following water activities:

☐ water table play ☐ sprinkler play ☐ splashing/wading pools ☐ swimming pools ☐ aquatic playgrounds

Is your child able to swim without assistance: ☐ Yes ☐ No

If no, your child is required to wear a life jacket while in or near a swimming pool

Is your child a competent swimmer*: ☐ Yes ☐ No

Does your child have any physical, health, or other conditions that would put them at risk while swimming?

☐ Yes ☐ No *If yes, your child is required to wear a life jacket while in or near a swimming pool.*

*A competent swimmer can enter and exit a pool safely on their own, tread water or float on their back for one minute, and swim 25 years with no assistance.

4. RECEIPT OF WRITTEN OPERATIONAL POLICIES

I acknowledge receipt of the facility's operation policies, including those for:

☐ Discipline and Guidance
☐ Suspension and expulsion
☐ Safe sleep
☐ Procedures for release of children
☐ Emergency plans
☐ Procedures for conducting health checks
☐ Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions
☐ Illness and exclusion criteria
☐ Procedures for dispensing medications
☐ Immunization requirements for children
☐ Meals and food services practices
☐ Procedures to visit the center without securing prior approval
☐ Procedures for parents to discuss concerns with Director
☐ Procedures for parents to contact Child Care Licensing, DFPS, Child Abuse Hotline, and DFPS website
☐ Procedures for parents to participate in operations activities

5. MEALS

I understand that the following meals will be served to my child while in care (check all that apply):

☐None ☐Breakfast ☐Morning Snack ☐Lunch ☐Afternoon snack ☐Supper ☐Evening Snack

6. DAYS AND TIMES IN CARE

My child is normally in care on the following days:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

During the hours of: _____ ☐am ☐pm thru _____ ☐am ☐pm

7. RECEIPT OF PARENT'S RIGHTS

I acknowledge I have receive a written copy of my rights as a parent or guardian of a child enrolled at this facility.

Parent or Legal Guardian: Date Signed:

X_____ _____

Child's Special Care Needs

CHECK ALL THAT APPLY:

- ☐ Environmental allergies
- ☐ Food intolerances
- ☐ Existing illness
- ☐ Previous serious illness
- ☐ Injuries and hospitalizations (past 12 months)
- ☐ Limitations or restrictions on child's activities
- ☐ Reasonable accommodations or modifications
- ☐ Adaptive equipment (include instructions below)
- ☐ Symptoms or indications of complications
- ☐ Medications prescribed for long-term use
- ☐ Other:_____

Explain any needs selected above: _____

_____

Does your child have diagnosed food allergies: ☐ Yes ☐ No

Food Allergy Emergency Plan Submitted Date:_____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Signature – Parent or Legal Guardian:

School Age Children

My child attends the following school:

Name of School _____Grade _____ School Phone No_____

Child's required immunizations, vision, hearing, and TB records are current and on file at school: ☐ Yes ☐ No

My child has permission to (Check all that apply):

☐ walk to or from school or home ☐ ride a bus ☐ be released to the care of his/her sibling under 18 years old

☐ Other: _____

Authorized pick up/drop off locations other than the child's address:_____

_____

Authorization for Emergency Medical Attention

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician_____Phone Number_____

Address_____

Name of Emergency Care Facility_____Phone Number_____

Address_____

I give consent for the facility to secure any and all necessary emergency medical care for my child.

Signature – Parent or Legal Guardian:

Requirements for Exclusion from Compliance

☐ I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.

☐ I have attached a signed affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

Vision Exam Results

Right Eye 20/ Left Eye 20/ ☐ Pass ☐ Fail

_____ _____

Signature Date Signed

Hearing Exam Results

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				☐Pass ☐Fail
Left				☐Pass ☐Fail

Signature

Date Signed

Admission Requirement

If your child does not attend pre-kindergarten or school away from the child care operation, one of the following must be presented when your child is admitted to the child care operation or within one week of admission. *(Select **only one** option.)*

- ☐ Health Care Professional's Statement: I have examined the above named child within the past year and find that he or she is able to take part in the day care program.
- ☐ A signed and dated copy of a health care professional's statement is attached.
- ☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.
- ☐ My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and submit it to the child care operation.

Name of Health Care Professional, if selected

Address of Health Care Professional, if selected

Signature — Health Care Professional

Date Signed

Signature — Parent or Legal Guardian

Date Signed

Vaccine Information		
The following vaccines require multiple doses over time. Please provide the date your child received each dose.		
Vaccine	**Vaccine Schedule**	**Dates Child Received Vaccine**
Hepatitis B	Birth (first dose)	
	1–2 months (second dose)	
	6–18 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15–18 months (fourth dose)	
	4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6–18 months (third dose)	
	4–6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12–15 months (first dose)	
	4–6 years (second dose)	
Varicella	12–15 months (first dose)	
	4–6 years (second dose)	
Hepatitis A	12–23 months (first dose)	
	The second dose should be given 6 to 18 months after the first dose.	

Varicella (Chickenpox)

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the following statement statement:
My child had varicella disease (chickenpox) on or about _____ (date) and does not need the varicella vaccine.

Signature – Parent or Legal Guardian:

TB Test (if required)

☐ Positive ☐ Negative Date:_____

Additional Information Regarding Immunizations

For additional information regarding immunizations, visit the Texas Department of State Health Services' website at www.dshs.state.tx.us/immuniz/public.shtm.

Gang Free Zone

Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

Privacy Statement

DFPS values your privacy. For more information, read the Privacy and Security Policy online at Http://www.dfps.state.tx.us/policies/privacy.asp.

Signatures

Child's Parent or Legal Guardian:

X_____ Date Signed: _____

Center Designee:

X_____ Date Signed: _____

Physician or Public Health Personnel Verification

Signature or stamp of a physician or public health personnel verifying immunization information above:

_____ _____

Signature Date Signed

*USE THIS FORM IF YOU **WANT** YOUR CHILDCARE ACCOUNT ON AUTO-PAY*

Childcare Payment Agreement 2025-2026

Child's Name _____ Parent/Guardian Name _____

Child's date of birth _____ Phone Number _____

PAYMENT OPTION 1 – AUTOPAY

- Tuition fees are due weekly and will be deducted from my Bank Account or Credit/Debit Card **EVERY FRIDAY BY 2:00pm**, for the following week of child care.
  Initials _____
- If my child does **NOT** attend a week, I will still be responsible for a **full week of tuition**.
  Initials _____
- A $25 late fee applies to all payments made after the due date. These fees WILL NOT be waived.
  Initials _____
- A $30 return fee applies to any payments declined by my Financial Institution. These fees **WILL NOT** be waived.
  Initials _____
- If I pick up my child later than the designated pick up time, I will be charged a late pick-up fee of $1 per minute.
  Initials _____
- Payments, late fees and past due balances must be paid in full before the child or family members can return to any YMCA Program, Child Care or Membership.
  Initials _____
- Enrollment fees are **NON-REFUNDABLE**.
  Initials _____
- It is my responsibility to know when my Financial Assistance expires. Should my FA expire, I will pay full rate until my FA has been renewed. (Allow 2 weeks for application processing)
  Initials _____
- The auto-draft is a continuous payment plan that will remain in effect until I request to terminate my child care account.
  Initials _____
- If I wish to terminate or change my child care account in any way, I must give the Membership Director, Julia Maseda, a **TWO WEEK NOTICE** via email at jmaseda@ymcagoldencrescent.org or phone 361-551-2562
  Initials _____

AUTOMATIC PAYMENT INFORMATION
Credit/Debit Card Payments

PAYMENTS DRAFTED BETWEEN 12:00AM - 11:59PM

Card Type: ☐ MASTERCARD ☐ VISA ☐ AMEX ☐ DISCOVER

Name on Card _____ Card Number _____

Expiration Date _____ Security Code: _____

Billing Address _____

City/ST/Zip: _____

******Effective 01/01/2025, a flex fee of 3% will be imposed on all credit card transactions******

Bank Account Payments

ALLOW UP TO 10 DAYS TO REFLECT ON YOUR BANK ACCOUNT

Account Type: ☐ Checking ☐ Savings

Name of Bank _____ Name on Bank Account _____

Routing Number _____ Account Number _____

Signature of person responsible for payments: Date Signed:

X _____ _____

*USE THIS FORM IF YOU **DO NOT WANT** YOUR CHILDCARE ACCOUNT ON AUTO-PAY*

Childcare Payment Agreement 2025-2026

Child's Name _____ Parent/Guardian Name _____

Child's date of birth _____ Phone Number _____

PAYMENT OPTION 2 – IN-HOUSE PAYMENTS

- Tuition fees are due by **8pm, EVERY FRIDAY**, for the following week of child care.
  Initials _____
- If my child does **NOT** attend a week, I will still be responsible for a **full week of tuition**.
  Initials _____
- A $25 late fee applies to all payments made after the due date. These fees **WILL NOT** be waived.
  Initials _____
- A $30 return fee applies to any payments declined by my Financial Institution. These fees **WILL NOT** be waived.
  Initials _____
- If I pick up my child later than the designated pick up time, I will be charged a late pick-up fee of $1 per minute.
  Initials _____
- Payments, late fees and past due balances must be paid in full before the child or family members can return to any YMCA Program, Child Care or Membership.
  Initials _____
- Enrollment fees are **NON-REFUNDABLE**.
  Initials _____
- It is my responsibility to know when my Financial Assistance expires. Should my FA expire, I will pay full rate until my FA has been renewed. (Allow 2 weeks for application processing)
  Initials _____
- If I wish to terminate or change my child care account in any way, I must give the Membership Director, Julia Maseda, a **TWO WEEK NOTICE** via email at jmaseda@ymcavictoria.org or phone 361-551-2562
  Initials _____

AUTOMATIC PAYMENT INFORMATION
Credit/Debit Card Payments

INSTANT DEBIT

Card Type: ☐ MASTERCARD ☐ VISA ☐ AMEX ☐ DISCOVER

Name on Card _____ Card Number _____

Expiration Date _____ Security Code: _____

Billing Address _____

City/ST/Zip: _____

******Effective 01/01/2025, a flex fee of 3% will be imposed on all credit card transactions******

Bank Account Payments

ALLOW UP TO 10 DAYS TO REFLECT ON YOUR BANK ACCOUNT

Account Type: ☐ Checking ☐ Savings

Name of Bank _____ Name on Bank Account _____

Routing Number _____ Account Number _____

Signature of person responsible for payments: Date Signed:

X _____ _____